Kansas Department on Aging

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
ANDILANC	O CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COWII EL	-120
		N089063	B. WING		07/1	₹   <b>4/2016</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ATRIA HE	ARTHSTONE EAST		TH AVENUE			
		TOPEKA, P	S 66606			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
{S 000}	INITIAL COMMENTS		{S 000}			
		s are the result of a ducted at the above named on 7/11/16, 7/12/16, 7/13/16				
S 115 SS=E	26-39-103 (d) Reside Records	nt Right Inspection of	S 115			
	that each resident or representative is afformation administrator or operation provide a photocopy of requested sections of each resident or resident to the copy, and not exceed actual (2) The administrator access to each resident or resident or the copy, and not exceed actual (2) The administrator access to each resident or resident or resident or the copy, and not exceed actual (2) The administrator access to each resident or reside	r or operator shall ensure resident's legal rded the right to inspect				
	This STANDARD is r KAR-39-103 (d) (2)	not met as evidenced by:				
	included 3 residents, one focus review resi and record reviews fo failed to ensure acces	and photocopying by any				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		N089063	B. WING		R 07/14/2016	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
ATRIA HE	ARTHSTONE EAST		KS 66606			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLE	ETE
S 115	Continued From page	: 1	S 115			
	to resident records wa Administrative staff #I are partially located of medication records) at electronic system (in- Requested user name electronic records.  On 7/11/16 at 12:43 pt " Corporate says they access to records. " complete access to re regulation and a user needed. Administration	B stated resident records in paper charts (including and partially on their cluding nursing notes). e and password to access implicensed staff #A stated, indon't allow electronic Staff was informed				
	stated corporate office profile set up to allow providers. Facility wil are requested. Regu	administrative staff #B e says they do not have a electronic access to outside I print off whatever records lation KSA 39-935 given to 3 to read, copy and send to				
	again requested, adm Still working on it, we need. "Requested h regarding lack of acce records. Requested a	electronic access code ninistrative staff #B stated, " can print you what you le/she call department less to resident electronic and received print copies of cords for sampled residents.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R
		N089063	B. WING		07/14/2016
NAME OF PE	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
ATRIA HE	ARTHSTONE EAST		6TH AVENUE , KS 66606		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX TAG	,	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
S 115	Continued From page	2	S 115		
	On 7/11/16 at 5:25pm resident records conti				
	access to each reside	operator failed to ensure nt 's records for inspection any representative of the			
S 135 SS=D	26-39-103 (h) Resider Changes	nt Right Notification of	S 135		
	that designated facility consult with the resider the resident's legal refamily member, if known of the following:  (A) An accident involvin injury and has the physician's intervention (B) a significant changemental, or psychosoci (C) a need to alter trefully a decision to transpresident from the adult (2) The administrator that a designated staff resident, the resident' authorized family merital to the resident to the staff resident, the resident' authorized family merital transport to the staff resident, the resident's authorized family merital transport to the resident transport to the resident transport trans	or operator shall ensure y staff inform the resident, ent's physician, and notify presentative or designated wn, upon occurrence of any  ing the resident that results potential for requiring a on; ge in the resident's physical, al status; atment significantly; or affer or discharge the t care home. or operator shall ensure f member informs the s legal representative, or nbers whenever the ber learns that the resident			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		N089063	B. WING		R <b>07/14/2016</b>
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	
ATRIA HE	ARTHSTONE EAST		STH AVENUE KS 66606		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
S 135	Continued From page	3	S 135		
	This STANDARD is r KAR 26-39-103 (h)(1)	not met as evidenced by: o(A)(B)(D)			
	The sample included residents and one for on record review and sampled resident and resident, the administ designated facility stass physician upon occur involving the resident the potential for requisintervention, a signification of sphysical status and resident from the adular Findings included:  - Record review for readmission date of 3/3 COPD (chronic obstruant dementia).  Functional Capacity of recorded resident to resident to resident to resident to resident to resident recorded resident to resident recorded resident to resident to resident recorded resident recor	eant change in the resident ' a decision to transfer the lt care home.  esident # 1712 recorded 1/14 with diagnoses of active pulmonary disease)  Screen (FCS dated 7/31/15 quired assistance with hagement of medications has a history of  greement/ Health Care CSP) dated 7/31/15 eccive assistance with hagement of medications ll risk with staff to provide			
	Resident notes conta	ins entry on 6/27/16,			

NAME OF PROVIDER OR SUPPLIER  ATRIA HEARTHSTONE EAST  3415 SW 6TH AVENUE TOPEKA, KS 68608  [X4)1D PREFIX PR		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S	
NAME OF PROVIDER OR SUPPLIER  ATRIA HEARTHSTONE EAST  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL FREDULATORY OR LISC DENTIFYING INFORMATION)  S 135  Continued From page 4 resident was seen by nurse practitioner.  Review of next resident note dated 777/2016 at 4:00pm recorded: "resident returned from hospital after fall this morning, new diagnosis of closed nondisplaced fracture of greater tuberosity of left humerus."  Record lacked documentation of notification of resident's physician of fall and transfer from the adult care home.  Interview on 7/12/16 at 2:37 pm with licensed staff #C confirmed record lacked notification of physician.  Record review of closed record for resident # 17/14 recorded admission date of 7/18/12 with diagnoses of Paget disease, edema, hypertension and Alzheimers.  Functional Capacity Screen (FCS) dated 3/15/16 recorded resident required assistance with bathing, dressing, tolleting and management of medications and treatments.  Negotilated service agreement dated 3/15/16 recorded resident to receive assistance with bathing, dressing, tolleting and management of medications.			N089063	B. WING		1	
ATRIA HEARTHSTONE EAST    CAN ID   PREVIX   SUMMARY STATEMENT OF DEFICIENCISS   PREVIX   GEACH DEFICIENCY MUST BE PRECEDED BY FULL   PREFIX   GEACH DEFICIENCY MUST BE PRECEDED BY FULL   PREFIX   REDULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX   TAG   PREFIX   CROSS-REFERENCE TO THE APPROPRIATE   DOMESTIC DEFICIENCY	NAME OF P	ROVIDER OR SUPPLIER		ORESS CITY STA	TE ZIP CODE	1 077	14/2010
SUMMARY STATEMENT OF DEFICIENCIES   SUMMARY STATEMENT OF DEFICIENCIES   PREFIX   TAG   PROVIDERS PLAN OF CORRECTION (CACHO DEFICIENCY MUST BE PRECEDED BY FULL TAG   PREFIX TAG   PROVIDERS PLAN OF CORRECTION (CACHO SHOULD BE CROSS-AEF-RENDED OF THE AFFACHATE DEFICIENCY)    S 135   Continued From page 4   S 135			3415 SW 6	TH AVENUE	, 000_		
resident was seen by nurse practitioner.  Review of next resident note dated 7/7/2016 at 4:00pm recorded: "resident returned from hospital after fall this morning, new diagnosis of closed nondisplaced fracture of greater tuberosity of left humerus."  Record lacked documentation of notification of resident's physician of fall and transfer from the adult care home.  Interview on 7/12/16 at 2:37pm with licensed staff #C confirmed record lacked notification of physician.  Record review of closed record for resident # 1714 recorded admission date of 7/18/12 with diagnoses of Paget disease, edema, hypertension and Alzheimers.  Functional Capacity Screen (FCS) dated 3/15/16 recorded resident required assistance with bathing, dressing, toileting and management of medications and treatments.  Negotiated service agreement dated 3/15/16 recorded resident to receive assistance with bathing, dressing, toileting and management of medications.	PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
Review of resident notes dated 2/13/2016, 9:18am; recorded: staff reported resident complaining of abdominal pain and started to vomit this morning Called DPOA (durable power of attorney)She stated monitor him for a couple hours and see  Record lacked documentation of consultation with resident 's physician regarding change of	S 135	resident was seen by Review of next resided 4:00pm recorded: "hospital after fall this closed nondisplaced of left humerus."  Record lacked docum resident 's physician adult care home.  Interview on 7/12/16 #C confirmed record physician.  Record review of close 1714 recorded admiss diagnoses of Paget de hypertension and Alzer Functional Capacity Serecorded resident recorded resident recorded resident recorded resident to bathing, dressing, to bathing of abdorvomit this morning power of attorney) a couple hours and service agreement of attorney) a couple hours and service agreement of attorney and service agreement of a serv	ent note dated 7/7/2016 at resident returned from morning, new diagnosis of fracture of greater tuberosity  mentation of notification of of fall and transfer from the  at 2:37 pm with licensed staff lacked notification of  sed record for resident # sion date of 7/18/12 with isease, edema, heimers.  Screen (FCS) dated 3/15/16 quired assistance with leting and management of tments.  greement dated 3/15/16 receive assistance with leting and management of the staff lacked 2/13/2016, taff reported resident minal pain and started to Called DPOA (durable .She stated monitor him for ee	S 135			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			7.1. 50.25.1.10.		R
		N089063	B. WING		07/14/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
ATRIA HE	ARTHSTONE EAST		6TH AVENUE		
			KS 66606		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
S 135	Continued From page	: 5	S 135		
	condition.				
		at 3:45 with licensed nurse # cked consultation with			
	closed review resident ensure that designate the resident's physic	d resident and 1 (#1714) t, the administrator failed to d facility staff consult with ian upon occurrence of an			
	injury and has the pot physician 's intervent the resident 's physic	resident that results in ential for requiring a ion, a significant change in al status and a decision to rom the adult care home.			
S3028 SS=D	26-41-101 (f) (3) Staff Reporting	Treatment of Residents	S3028		
	or operator of the faci of the allegation and thours. The administration and thours. The administration of that all of the following (A) An investigation is administrator or operatoreceives notification of (B) Immediate measurement further potent exploitation while the (C) Each alleged violation with the investigated within five report. Results of the reported to the admin (D) Appropriate correct the alleged violation is	eported to the administrator lity as soon as staff is aware to the department within 24 actor or operator shall ensure grequirements are met: shall be started when the actor, or the designee, of an alleged violation. The area shall be taken to ial abuse, neglect, or investigation is in progress. Sation shall be thoroughly the working days of the initial investigation shall be istrator or operator. Cotive action shall be taken if its verified.			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLE	
			7 50.25 10.		l R	•
		N089063	B. WING		I	4/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ATRIA HE	ARTHSTONE EAST	3415 SW 67 TOPEKA, K	TH AVENUE			
(Y4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	J	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETE DATE
S3028	Continued From page	e 6	S3028			
	initial report.	hin five working days of the nall be maintained of each ted abuse, neglect, or				
	This REQUIREMENT by: KAR 26-41-101 (f) (1)	is not met as evidenced				
	The sample included residents and 1 focus record review and into record review resident ensure that allegation were reported to the can investigation was the department's controlled.	a census of 64 residents.  3 residents, 3 closed review review resident. Based on erview for 1 (#1714) closed at, the administrator failed to a sof abuse and neglect department within 24 hours, started of the violation and amplaint investigation reports submitted to the department ys of the initial report.				
	Findings included:					
		esident # 1714 recorded 8/12 with diagnoses of a, hypertension and				
	recorded resident req bathing, dressing, toil medications and treat problems with short to	eting and management of tments. Resident has erm and long term memory, ecision making, he/she also				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S COMPLE	
			_		R	2
		N089063	B. WING		07/1	4/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ATRIA HE	ARTHSTONE EAST	3415 SW 67 TOPEKA, K	TH AVENUE			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	<b>N</b>	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	COMPLETE DATE
S3028	Continued From page	7	S3028			
	expressing informatio	n to others.				
	Negotiated service ag Service Plan (HCSP) resident to receive as dressing, toileting and medications.	dated 3/15/16 recorded sistance with bathing,				
	resident was found or					
	#C stated according to the fall was not witness department. He/she so to the department if a Resident notes dated following: "Resident when another resident looking at the fish with resident became upset.	3/28/16 recorded the t was sitting at the fish tank at approached and began h him/her. The other et stating that they could not The other resident then hit				
	# C confirmed resider 3/28/16 was not report For resident #1714, thensure that allegation reported to the depart	at 4:05pm with licensed staff of to resident incident of rted to the department.  The administrator failed to use of abuse and neglect were the to the violation and the				
	department 's completed and s	aint investigation reports submitted to the department ys of the initial report.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			7.1. 56.25.116.		R
		N089063	B. WING		07/14/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
ATRIA HE	ARTHSTONE EAST		6TH AVENUE KS 66606		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
{S3101}	Continued From page	8	{S3101}		
{S3101} SS=D	26-41-202 (h) NSA Si	gnatures	{S3101}		
	the negotiated service agreement. The adm ensure that a copy of any subsequent revis	volved in the development of agreement shall sign the inistrator or operator shall the initial agreement and ions are provided to the nt's legal representative.			
	This REQUIREMENT by: KAR 26-41-202(h)	is not met as evidenced			
	included 3 residents, residents and one foc on interviews and rec record review residen	_			
	Findings included:				
	admission date of 7/1 Paget disease, edema Alzheimers. Functional Capacity S	Screen (FCS) dated 3/15/16			
	recorded resident req bathing, dressing, toil medications and treat	eting and management of			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R
		N089063	B. WING		07/14/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ITE, ZIP CODE	
ATRIA HE	ARTHSTONE EAST		6TH AVENUE KS 66606		
	CLIMMA DV CT/	·		DDOWNER DI AN OF CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
{S3101}	Continued From page	9	{S3101}		
	recorded resident to rebathing, dressing, toile medications. Agreem individuals involved in NSA.  Interview on 7/12/16 of confirmed NSA lacked involved in the developing and copy cannot be signed copy cannot be for resident #1714, that each individual in	d signatures of individuals pment of the NSA and a			
	signed the agreement	- · · · · · · · · · · · · · · · · · · ·			
S3155 SS=E	. (a) The administrator assisted living facility facility shall ensure the or coordinates the procare services that me resident and are in accordinates.	or or operator in each or residential health care at a licensed nurse provides ovision of necessary health	S3155		
	by: KAR 26-41-204(a) The facility reported a The sample included				

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7 BOILBING		R	
		N089063	B. WING		07/14/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
ATRIA HE	ARTHSTONE EAST	3415 SW 6 TOPEKA, I	TH AVENUE			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	I (X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLET	Έ
S3155	Continued From page	e 10	S3155			
	residents, 1 (#1717) f (#1714) closed record health care services, that a licensed nursed the provision of neces that meet the needs of accordance with the f and the negotiated se Findings included:  - Record review for r	focus review resident and 1 d review resident, requiring the operator failed to ensure d provides or coordinates sarry health care services of each resident and are in functional capacity screening ervice agreement.				
		80/16 with diagnoses of: c pain, alzheimers, dementia, etes type 2.				
	recorded resident req transfer, walk/mobility falls/unsteadiness, ha	y, has a history of as difficulty with long term nemory, memory recall and				
	service plan (NSA/HC resident to receive sta	greement/ Health care CSP) dated 6/30/16 recorded aff assistance with transfers, and hourly safety checks.				
	room on life guidance wheelchair by the bat on the floor by the be right side of the bed a	16 at 2:50pm in resident's e unit, revealed resident in a throom, large blue fall mat ed, a brown bed cane on the and a walker by the window. d easily moves out and side				
	#1711 in resident 's r	at 2:07pm with resident room on life guidance unit, what the bed cane was,				

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			A. BUILDING:			
		N089063	B. WING		R 07/14/	/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
ATRIA HE	ARTHSTONE EAST	3415 SW 6 TOPEKA,	TH AVENUE KS 66606			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
S3155	Resident responded, do that makes cold Observed at that time placed up against the NSA/HCSP lacked intand entries for use of cane and fall mat. Interview on 7/12/16 a #C and Licensed staf lacked entries for use stating they were una family must have brown Record review for resadmission date of 3/3 COPD (chronic obstruand dementia.  FCS dated 7/31/15 reindependent with tranhas a history of falls/to NSA/HCSP dated 7/3 identified as fall risk winterventions to decree Resident notes dated recorded the following hospital after fall this closed nondisplaced of left humerus. "  FCS dated 7/11/16 reassistance with transit a history of falls/unsterventions to falls/unsterventions of falls/unsterve	"The girls thought they 'dor for the coloring."  the blue fall mat was wall by the bed.  terventions for walk/mobility, a walker, wheelchair, bed  at 2:37pm with licensed staff of # A confirmed NSA/HCSP of bed cane and fall mat ware he/she had a fall mat, aught it in.  ident # 1712 recorded 1/14 with diagnoses of auctive pulmonary disease)  coorded resident was asfer, walking, mobility and unsteadiness.  1//15 recorded resident with staff to provide custom case fall risk.  7/7/2016 at 4:00pm of g: " resident returned from morning, new diagnosis of fracture of greater tuberosity corded resident required fer, walking/mobility and has	S3155			
	a fall risk with staff to					

NAME OF PROVIDER OR SUPPLIER  ATRIA HEARTHSTONE EAST  3415 SW STH AVENUE TOPEKA, KS 66606    CANDIDATE   CANDIDATE	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE C A. BUILDING:		(X3) DATE COMP	SURVEY LETED
ATRIA HEARTHSTONE EAST   SUMMARY STATEMENT OF DEFICIENCIES   FOREIGN   SUMMARY STATEMENT OF DEFICIENCIES   FOREIGN			N089063	B. WING			
CASH   Continued From page 12   S3155	NAME OF P	ROVIDER OR SUPPLIER			E, ZIP CODE		
PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION   REGULATORY OR LSC I	ATRIA HE	ARTHSTONE EAST					
interventions to decrease fall risk. NSA lacked custom interventions.  Observation on 7/11/16 at 2:25pm viewed resident by life guidance unit nurses station in a wheelchair with a skin tear and bruise on the left cheek and left arm in a sling.  Interview on 7/12/16 at 2:37pm with licensed staff #C stated resident was independent prior to fall/fracture and had no history of falls. Licensed staff #C confirmed 7/31/15 FCS was coded for falls/unsteadiness, fall intervention on 7/31/15 and 7/11/16 NSA/HCSP are generic, stating interventions are computer generated and no specific custom fall interventions are listed.  7/31/15 and 7/11/16 NSA/HCSP lacked interventions to address resident #1712 's fall risk, prior to and after resident fall with resulting fracture.  Record review for resident # 1714 recorded admission date of 7/18/12 with diagnoses of Paget disease, edema, hypertension and Alzheimers.  FCS dated 10/29/15 recorded resident as independent with transfers, required supervision with walking/mobility and had a history of falls/unsteadiness.  NSA/HCSP dated 1/26/15 recorded "fall risk: staff will provide custom interventions to decrease fall risk. Staff to ensure resident is wearing appropriate footwear. Provide a busy box for resident to thinker with. Monitor sign on back of	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	COMPLETE
at all times and notify LGD (life guidance director) if it needs to be replaced. "	S3155	interventions to decre custom interventions.  Observation on 7/11/resident by life guidar wheelchair with a skir cheek and left arm in  Interview on 7/12/16 a # C stated resident wifall/fracture and had restaff #C confirmed 7 falls/unsteadiness, fa and 7/11/16 NSA/HCs interventions are come specific custom fall in  7/31/15 and 7/11/16 interventions to addressis, prior to and after fracture.  Record review for reseadmission date of 7/1 Paget disease, edemontal Alzheimers.  FCS dated 10/29/15 resident with transwith walking/mobility afalls/unsteadiness.  NSA/HCSP dated 1/2 staff will provide custofall risk. Staff to ensurappropriate footwear. resident to tinker with apartment door reminat all times and notify	ase fall risk. NSA lacked  16 at 2:25pm viewed ace unit nurses station in a a tear and bruise on the left a sling.  at 2:37pm with licensed staff as independent prior to a history of falls. Licensed //31/15 FCS was coded for all intervention on 7/31/15 SP are generic, stating puter generated and no terventions are listed.  NSA/HCSP lacked ass resident #1712 's fall resident fall with resulting  ident # 1714 recorded 8/12 with diagnoses of a, hypertension and  recorded resident as sfers, required supervision and had a history of  6/15 recorded " fall risk: but interventions to decrease are resident is wearing Provide a busy box for . Monitor sign on back of ding resident to wear shoes LGD (life guidance director)	S3155			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		N089063	B. WING		R 07/14/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
ATRIA HE	ARTHSTONE EAST	3415 SW 6 TOPEKA,	TH AVENUE KS 66606		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
S3155	Continued From page	e 13	S3155		
	dates: 3/3/16 " resid guidance hallway on: 8:20pm, laceration to floor, wheelchair footr 10:17pm, " staff foun next to his wheelchair resident was found or Had on slip resistant of fall with no apparent in the NSA/HCSP lacked fall Record review for resident and the fall with no apparent in the NSA/HCSP lacked fall Record review for resident and the fall state of 3/2 (coronary artery disease hyperlipidemia, and dispersion of the fall state of falls/unsteadiness.  NSA/HCSP dated 4/2 Assistive/adaptive derequipment and assist (anti-thrombo-embolic Observation on 7/12/17 room revealed a queet transfer bars attached up position. Right side NSA/HCSP lacked erron the bed.	d resident on the wood floor "; 3/9/16 5:04am " n the floor in his/her room. " socks; 3/12/16 " resident njury @ (at) 12:30am. "  Ill interventions for falls.  ident #1717 recorded 5/16 with diagnoses of CAD ase), hypertension, ementia.  corded resident was sfer, walking/mobility, had erm and long term memory, ecision making, and a history  7/16 recorded vices: staff to check resident with TED hose sm stockings)  16 at 2:15pm in resident 's en size bed with 2 black d, one on each side, both in the bar was loose.  Intry for use of transfer bars			
		at 2:37pm with licensed staff t uses the transfer bars, and			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		R
		N089063	B. WING		07/14/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
ATRIA HE	ARTHSTONE EAST		OTH AVENUE		
		<u> </u>	KS 66606		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
S3155	Continued From page	e 14	S3155		
	confirmed lack of entr NSA/HCSP.	y for transfer bars on			
	#C and administrative not have a policy on b	at 2:37pm with licensed staff e staff #A stated facility does bedrails/bed canes, does not eed/ability to use and does ecks.			
	required health care s to ensure that a licens coordinates the provis care services that me resident and are in ac	sion of necessary health			
{S3165}	26-41-204 (d) Health	Care Services	{S3165}		
SS=E	contain a description to be provided and the	ervice agreement shall of the health care services e name of the licensed the implementation and n.			
	This REQUIREMENT by: KAR 26-41-204(d)	is not met as evidenced			
	The sample included residents and one for on record review and sampled residents an review residents, the negotiated service ag	a census of 64 residents.  3 residents, 3 closed review resident. Based interview, for 1 (#1712) of 3 d for 1 (#1714) of 3 closed operator failed to ensure the reement shall contain a lth care services to be			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLI	
			,		 	2
		N089063	B. WING		ı	4/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, STA	TE, ZIP CODE		
ATRIA HE	ARTHSTONE EAST	3415 SW 6T TOPEKA, K				
(X4) ID	SUMMARY ST/	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ı	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	COMPLETE DATE
{S3165}	Continued From page	<del>:</del> 15	{S3165}			
	provided and the name responsible for the im supervision of the pla					
	Findings included:					
	admission date of 3/3	esident # 1712 recorded 1/14 with diagnoses of uctive pulmonary disease)				
	recorded resident req bathing, dressing, toil	•				
	Service Plan (NSA/Horecorded resident to r	eceive assistance with eting, transfer, mobility, and cations and special				
		e of the nurse responsible for supervision of the HCSP.				
	Record review for res admission date of 7/1 Paget disease, edema Alzheimers.	8/12 with diagnoses of				
	recorded resident req	eting and management of				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURV COMPLETED	
					R	
		N089063	B. WING		07/14/2	016
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ITE, ZIP CODE		
ATRIA HE	ARTHSTONE EAST		TH AVENUE			
	OLIMANA DV. OTO	TOPEKA,		DROWDERIO PLANTOS CORRECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE C	(X5) COMPLETE DATE
{S3165}	Continued From page	<del>2</del> 16	{S3165}			
	Negotiated service ag Service Plan (HCSP) resident to receive as dressing, toileting and medications.	dated 3/15/16 recorded sistance with bathing,				
		of the nurse responsible for upervision of the HCSP.				
	nurse # D confirmed I	at 3:00pm with licensed ack of name of the nurse mentation and supervision of ts # 1712 and #1714.				
		plementation and				
{S3171} SS=E	26-41-204 (i) Health C Practice	Care Services Standards of	{S3171}			
		vices shall be provided to staff in accordance with of practice.				
	This REQUIREMENT by: KAR 26-41-204(i)	is not met as evidenced				
	The sample included residents and one foc on record review and sampled residents and review residents, the approvide health care see	a census of 64 residents.  3 residents, 3 closed review resident. Based interview for 1(#1712)  d 1 (#1714) of 3 closed administrator failed to revices to residents by rdance with acceptable				

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		R	
		N089063	B. WING		07/14/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
ATRIA HE	ARTHSTONE EAST	3415 SW 6 TOPEKA, I	TH AVENUE			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	I (X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLE	
{S3171}	Continued From page	e 17	{S3171}			
	standards of practice					
	Findings included:					
	admission date of 3/3	sident # 1712 recorded 31/14 with diagnoses of uctive pulmonary disease)				
	recorded resident re-	Screen (FCS dated 7/31/15 quired assistance with nagement of medications has a history of				
	Service Plan (NSA/H recorded resident to a bathing, toileting, man	receive assistance with nagement of medications Il risk with staff to provide				
	4:00pm recorded the returned from hospital	al after fall this morning, new ondisplaced fracture of				
	assessment at the tin	d evidence of a nursing ne of the fall, at the time of al and upon return from the				
		at 2:37pm with licensed staff lacked entry regarding				
		sident # 1714 recorded 8/12 with diagnoses of				

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		N089063	B. WING		R <b>07/14/2016</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ATRIA HE	ARTHSTONE EAST	3415 SW 67 TOPEKA, K	TH AVENUE S 66606			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLE	ETE
{S3171}	Continued From page	÷ 18	{S3171}			
	Paget disease, edem Alzheimers.	a, hypertension and				
	assistance with bathir	recorded resident required ng, dressing, toileting, cations and treatments and unsteadiness.				
	NSA/HCSP dated 1/2 receive assistance wi toileting and medicati					
	the life guidance hally	esident was found of floor in way on 3/1/16 at 4:35am plaints of pain family				
	assessment at the tim	d evidence of a nursing ne of the fall, at the time of al and upon return from the				
	reassessed by RN (re sent to hospital emerg transcribed from hand	30am 10:05am resident egistered nurse) resident gency room Nurses note dwritten note (written by e #E) note electronically				
	physical assessment signs and resident re- recorded 6 ½ hours a	d evidence of a nursing at time of fall including vital call of event. Entry was after incident. Licensed staff for another licensed nurse.				
	#D confirmed record	at 3:45pm with licensed staff lacked physical assessment falls and staff recorded				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			7 50.25		R
		N089063	B. WING		07/14/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
ATRIA HE	ARTHSTONE EAST	3415 SW 6 TOPEKA,	TH AVENUE KS 66606		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	
{S3171}	Continued From page	e 19	{S3171}		
		rd of events for him/her are not allowed computer			
	#D stated an assessn resident #1714 upon	at 4:05pm with licensed staff nent was not done on return from the hospital do those, we are not a			
	# C stated vital signs assisted living facilitie facility does not do vit not a skilled nursing fa policy on vital signs th	at 3:20pm with licensed staff are not done on falls in as per company policy, tal sign monitoring as it is acility. Requested facility nat states this. He/she later staken it is not a company			
	failed to provide healt	and #1714 the administrator the care services to residents ecordance with acceptable			
{S3261} SS=E	26-41-105 (f) (11) Res Documentation of Inc		{S3261}		
	and other indications	n of all incidents, symptoms, of illness or injury including irrence, action taken, and			
	This REQUIREMENT by: KAR 26-41-105(f)(11)	is not met as evidenced			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE  A. BUILDING:	CONSTRUCTION	(X3) DATE SU COMPLET	
		N089063	B. WING		R <b>07/14</b>	1/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	E, ZIP CODE		
ATRIA HE	ARTHSTONE EAST		6TH AVENUE			
			, KS 66606			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
{S3261}	Continued From page	20	{S3261}			
	The sample included review residents and Based on record revie (#1712) sampled resichart review resident, ensure documentation indications of injury in occurrence, action tall action.	dent and 1 (#1714) closed the administrator failed to n of all incidents and cluding date, time of				
	Findings included:					
	admission date of 3/3	esident # 1712 recorded 1/14 with diagnoses of uctive pulmonary disease)				
	assistance with bathir	corded resident required ng, toileting, management of the ments and has a history of				
	receive assistance wi management of medi	1/15 recorded resident to th bathing, toileting and cations and treatments. fall risk with staff to provide to decrease fall risk.				
		otes dated 6/27/16, 3:21pm s seen by nurse practitioner.				
	4:00pm recorded " re hospital after fall this	morning, new diagnosis of fracture of greater tuberosity				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R
		N089063	B. WING		07/14/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
ATRIA HE	ARTHSTONE EAST		6TH AVENUE , KS 66606		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	DN (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
{S3261}	Continued From page	21	{S3261}		
		nentation of resident fall on time of occurrence and			
		at with licensed staff #C ed documentation of 7/7/16			
	recorded resident req	eting and management of			
	recorded resident to r	greement dated 3/15/16 eceive assistance with eting and management of			
	Review of resident no recorded resident in c television.				
	The record lacked ad	ditional resident notes.			
	Review of list of resid facility recorded resid 4/15/16.	ents discharged from the ent " moved out " on			
	Interview on 7/11/16 a administrative staff #/ resident note was wri	A confirmed last recorded			
		at 4:05 pm with licensed sident was discharged on			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPL	
		N089063	B. WING		07/1	R I <b>4/2016</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
ATRIA HE	ARTHSTONE EAST	3415 SW 6 TOPEKA,	TH AVENUE KS 66606			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{S3261}	Continued From page	e 22	{S3261}			
{S3261}	4/15/16 and stated re nursing facility. He/s documentation of discording for residents #1712 administrator failed to all incidents and indicate.	esident went to skilled he confirmed lack of charge from facility.	{S3261}			